

**KanCare Advisory Council
Curtis State Office Building- Room 530, Topeka, Kansas
Minutes of March 26, 2014**

Council Members Present:

Dr. Michael Kennedy
Chairman Larry Martin
Walter Hill
Jamie Price
Mark Hinde
Beth Simpson
Edward Nicholas
Allen Schmidt
Senator Mary Pilcher-Cook
Lora Key

Council Members Absent:

Representative Jerry Henry
Representative Susan Concannon
Njeri Shomari

Council Members Attending Via Phone:

None

Other Participants:

Secretary Robert Moser, M.D., Kansas Department of Health and Environment
Secretary Shawn Sullivan, Kansas Department for Aging and Disability Services
Kari Bruffett, Director of KDHE Division of Health Care Finance
Susan Mosier, M.D., Medicaid Director

Other Participants Absent:

Lt. Governor Jeff Colyer, M.D.

Welcome – Dr. Mosier

Dr. Mosier opened the meeting by introducing Larry Martin who will serve as the Chairman for the KanCare Advisory Council.

Chairman Larry Martin asked the Advisory Council Member to introduce themselves and briefly describe their background and city where they reside.

Review and Approval of Minutes from Council Meeting, December 18, 2013.
The minutes were unanimously approved by the Council.

Updates on KanCare

UnitedHealthcare Community Plan – Tim Spilker

Tim Spilker provided a brief update on UnitedHealthcare.

- **I/DD Implementation:** Strong claims performance since go live, with a denial rate of 4% (3% excluding duplicate claims) and a turnaround time of 7 days or less. Reviewed 100% of claims prior to payment since 2/1. Continued progress on clinical engagement of DD members, with a focus on underserved members. Positive feedback from providers and TCMs. Quickly working through minor start-up issues as they arise.
- **Claims Payment Performance:** Continued focus on claims payment improvement projects. Key Update – Simplified retro eligible newborn claims submission process in place, which bypasses prior authorization requirement for normal births with hospital stays four days or less. Significant provider adjustment activity in Q4 and Q1. Overall claims payment timeliness remains strong with steady denial rate.
- **Key Program Successes:** JoinforMe designed for children ages 6-17 and fully engages the family as a proven community-based, childhood weight management, lifestyle-intervention program. The program includes rewards for participants achieving specific goals. Empower Kansans provides grant funding to community programs focused on supporting employment programs for individuals with developmental disabilities. Second round of grantees selected in February to provide funding for four additional programs. Upcoming: IronKids is a UHC sponsored race aimed to inspire and motivate youth to lead active, positive and healthy lifestyles, scheduled for June 7, 2014 in Lawrence.

Questions and Answers:

Allen Schmidt – Where is the problem with the 32% in duplicate claims?

Tim Spilker – Duplicate claims are very interesting and is a normal operating process. Example: If a provider submits a claim for a certain amount of hours and realize submitted wrong amount of hours, they may actually take the first claim out and resubmit the claim. In our system this shows as a duplicate claim. This is the reason we look at it both ways We would then go back and work with the provider and make sure they understand what they are doing right or wrong to reduce the number. This is the reason for looking at the overall denial rates without duplicates

Michael Kennedy – In reviewing slide 3 claims data it looks excellent, but is there bench marking data to compare to?

Tim Spilker – For some of our other claims types we are running a 10-15% denial rate. 3% is pretty consistent on what we would see on a commercial plan.

Amerigroup Kansas – Laura Hopkins

Laura Hopkins provided a brief update on Amerigroup.

- **I/DD:** Amerigroup has 2,700-2,800 DD members and have been working closely with those participants, families and their target case managers since February 1st. 900 face to face meetings.
- 12 Provider training sessions in person or via WebEx since February 1st.
- Processed 34,000 claim lines since February 1st and paid \$8.2 million. Approximately \$290,000 was denied or 3.5%. This is inclusive of duplicate claims. Scan for denials weekly looking for avoidable denials providers made and also reaching out to educate them.
- **I/DD** Year to date turnaround claim time is 5 days. Claims are processed 6 days per week.
- Working on additional automation for client obligation.
- New Provider facing web portal that is more users friendly coming soon.
- Continue to increase the number of joint operating committees for specific providers.

Questions and Answers:

Michael Kennedy – Clarification: Does each I/DD member have a case manager?

Laura Hopkins – Yes and a service coordinator is assigned as well.

Michael Kennedy – Could you provide number or percent of I/DD members who have been contacted to date?

Laura Hopkins – Approximately 1/3 have been contacted.

Walter Hill – Do you have a comment/expectation on benchmarks for claim payments?

Laura Hopkins – The 5 day turnaround time is holding very closely to all provider types. In other markets we do not have such an aggressive contractual requirement. In other states it is whatever the regulatory requirement is for commercial which is 30 days, so usually other markets are about 15 days. If we have specific requirements we make sure we come in under the mark.

Sunflower State Health Plan – Mike McKinney

Mike McKinney provided a brief update on Sunflower State Health Plan.

- Mike announced he has been President since February.
- Little shift in emphasis. One that is probably been present all along but emphasizing it is our job to take care of the members, pay providers for taking care of our members. This has been a change welcomed by the members.
- I/DD population – Sunflower has 48% of this population with another 650 on a waiting list. Previously had 1 employee to 500 members; currently 1 employee to 95 members. Fewer employees in administration as before. Currently reached out to 18 on the group classified underserved to help bring services to them.
- Rapid Response Program – Teams physically positioned around the state and include behavioral health specialists, case management, working with CDDOs and providers. 1 team has been activated 40 different times since February 1st.
- Pathways (Program) – Provide support and training to members and their families. Help them to seek employment and to perform more self direction in their care.
- Continue to report daily on claim denials. 5 days average time to pay claims.
- Do not read too much into duplicate claims.

Questions and Answers:

Beth Simpson – What is the rejection rate?

Mike McKinney – Do not have an answer for this. Claims go through KMAP and then transmitted to our claims payment system. There are edits in the claim processing and if things edited out from KMAPS our system takes whatever they send. If it is unrecognized by our system it will be rejected. Believe with KMAP there will be ongoing issues and through the years will need to figure out how not to have it.

Walter Hill – Would like to offer in terms of the KMAP issue as we are approaching Health Homes implementation we are looking at some population management analytics that really rely upon KMAP opposed to the 3 individual MCO claim data bases.

Secretary Sullivan – We are not planning to get rid of KMAP.

Kari Bruffett – The ability to use front end billing is voluntarily for providers but the KMAP also receives claims copy of all claims sent directly to the managed care organizations or through a clearing house. The rejection rate through the KMAP billing is not high. We can get these stats and share with the committee.

Q & A with KanCare MCO's – Director Kari Bruffett, Division of Health Care Finance, Kansas Department of Health and Environment

Question and answer session occurred after each MCO update.

Update on I/DD Implementation – Secretary Shawn Sullivan, Kansas Department for Aging and Disability Services

Secretary Sullivan provided an update on I/DD Implementation.

Billing: The data is through 3/23/14. A total of \$33,344,288 has been billed for HCBS/IDD, and a total of \$29,610,230 has been paid. There is \$2,568,557 in process. The remainder has been denied, mainly due to duplicate claims. A total of \$950,362 has been billed for IDD/TCM, and a total of \$848,409 has been paid. There is \$94,898 in process. A small amount (\$12,000) has been denied. The state average for turnaround time from claims submission to claims payment for HCBS/IDD and TCM/IDD is 5.3 days. 120,918 claims have been received. Only 2,943 have been denied, this equates to 2.4% denial rate. The top HCBS/TCM denial reasons are: Non-covered service/item, service not authorized, service limit exceeded without PA, member not eligible, provider not contracted for service, duplicate claim, error in billing (procedure code, NPI, etc), date of service not covered, exceeds filing time limit, claim and PA not matching, denial required from primary insurance (TPL). There are 1,717 denials for duplicate claims. This compares favorably to pre-KanCare and to experience in KanCare. As far as actual provider feedback, most have said things are going better than expected and have used frequently the term "cautiously optimistic". Thank you to the providers and MCOs for working so diligently on this. One main issue identified to correct is the client obligation withholding.

RASL: 1,700 letters sent out to the underserved in January. 1,400 of those had current requests for services. 950 responses received to date. 55% request services within next year and 45% request services more than one year. All 1,700 are in the process of being assessed by MCO and TCM.

Stakeholder Outreach: Provider call 2 times weekly but changing to 1 time weekly. Individual/family, TCM and CDDO calls occur 1 time weekly. Educational sessions for TCMs: MCOs vs TCM clarification, TCM billing, need assessments, process for RASL, billing clarification and DD renewal questions. Friends/Family group video on MCO/TCM roles, Facebook pages, outreach to various events.

DD Waiver Renewal: Year 5 of waiver. Submissions to CMS by end of month. The RFI was sent out and had listening sessions. Topics have surrounded guardians as paid providers, training, supported employment, assessment process, impact of new federal rules. The waiver submitted will include eliminate conflicts around guardians as paid providers. The waiver will also have a transition plan required to be submitted 90 days after renewal submission and will address a number of topics during this time.

Questions and Answers:

Allen Schmidt – Could we go over the number again? Currently 700 on the underserved list?

Secretary Sullivan – 1,700.

Allen Schmidt – 1,000 responses?

Secretary Sullivan – 1,000 responses. We are going to go out and do assessments on everyone else in the first 6 months that respond and say I have this additional need. We will prioritize and set up a visit.

Beth Simpson – Is there a time line of when this will be accomplished?

Secretary Sullivan – Our intent is to have of those on the underserved list that indicate they want additional service and assess needed by August 1st. If assess needed right away the MCO will start the process.

Beth Simpson – What does the provider capacity look like?

Secretary Sullivan – We did a survey and worked with the 27 CDDOs. We are still clarifying and working through the responses and have that data for each area of the state. Where there appears to be a need for additional capacity we will work with CDDOs and MCOs to enhance this.

Beth Simpson – Feedback has been good. Do you have a timing of when the edits will be turned back on?

Secretary Sullivan – A couples of edits were eased with this transition. This was one of the lessons learned from last year that we cannot flip a switch all at once. During the upcoming months will turn each edit off one by one, if the systems allow, with a small group of providers to ease the edits.

Michael Kennedy – Concern that people on underserved list will be left out of process. What are you doing to identify these individuals and what services will be available to them?

Secretary Sullivan – We have asked the MCOs to be creative finding ways to address this concern. Surprising Johnson County has a lack of provider residential in home supports so that leads people to go to residential placement before they or the family would like. These are easier to address than areas where there is a shortage of homes replacements.

Allen Schmidt – Several issues out west with 2-3% unemployment and do not have housing in the community.

Secretary Sullivan – One of our goals with this is to have more people stay at home and some have taken this to mean we are forcing them to stay home but this is not the case. Sometimes families can remain at home if technology is in place for some additional things the system did not traditionally pay for.

Jamie Price – Would like to concur billing has gone better than expected across all three managed care organizations with the first few months of implementation. From the provider prospective we greatly appreciate it. There were bumps in the road and the MCOs were more than willing to come to the table and work through difficult issues and concerns. On the capitation payment long term support groups and services were combined and is there an ability to get those groups separated out?

Kari Bruffett – Absolutely, we can certainly provide this.

Overview of Healthy Kansans 2020 – Secretary Bob Moser, MD, Kansas Department of Health and Environment

Healthy People 2020 came out in 2010 and with this there were about 42 different focus areas and 1,500 objectives. For a few years a number of surveys sent to over 1,700 Kansans and some subject matter experts, to review the 1,200 objectives in the 42 areas. In 2012, 100 stakeholders came together and reviewed 12 of these focus areas and data for Kansas and how Kansas is doing in a number of areas from dental decay to teenage pregnancy rates to infant mortality, etc. Out of this initial 2 day meeting the Healthy Kansans 2020 handout was developed.

Mission Statement for Healthy Kansans 2020: Working together, working smarter to routinely connect state and local partners across disciplines and sectors to enhance implementation of innovative systems and strategies, and improve individual and community well-being in Kansas by 2020.

Three cross-cutting themes and priority strategies were developed: Healthy Living – Kansans equipped to take an active role in improving their health and supporting their families and friends in making healthy choices. Healthy Communities – Kansans working together to impact the natural as

well as human-formed conditions that influence health and/or risk for injury. Access to Services – Kansans ready access to information and health and social services to achieve the best health outcomes. In 2013 another meeting occurred with 100 stakeholders and broke down to top 5 strategies with group activities. The five strategies are broken down into approach, activity and current resources/initiatives (open at this time). The Potawatomi Nation sponsored the location for the first 2020 Healthy Kansans tribe meeting held in September 2013. KDHE is fortunate to work with our sovereign nations in developing their own community health assessment and after that their community health improvement plans. The county health rankings came out today. The score is determined from actual clinical services. 20% comes from actual clinical services and 70% comes from social economic and healthy behavior at risk factors. We will continue to work with our MCOs to determine our state health improvement plan, particularly focusing on our Medicaid population.

External WorkGroups

Consumer and Specialized Issues Workgroup – Russell Nittler

Russell Nittler, KDHE and Joe Ewert, KDADS co-chair the KanCare Consumer and Specialized Issues Workgroup (CSI) with quarterly meetings. The CSI group grew out of the Member Involvement and Protection Workgroup and is made up of advocates and consumers or their family members. This group hears information about how KanCare works, previews papers used to educate people about KanCare and accepts feedback, gives advice and suggestion about KanCare and makes sure different people get to present their views about KanCare. The committee has discussed the Affordable Health Care Act and its effects on KanCare, the new KEES eligibility system and its effect on eligibility reviews. Open enrollment packet material and timeliness of the open enrollment process has been reviewed. The committee has also looked over the MCO Value Added Services and how they were used during the first year of KanCare. The committee has acted on some suggestions received from members which include notification alerts now found on the website's home page and guardians listed in the system for nursing home patients now receiving the open enrollment packets.

Provider and Operational Issues Workgroup – Shirley Norris

Shirley Norris, KDHE and James Bart, KDADS co-chair the Provider and Operational Issues Workgroup (POI). The POI session is centered on what they would like to see from KanCare and the Managed Care Organizations. Discussion took place on utilization data and asked for suggestions on what type of data. The responses were as follows: 1) How is KanCare progressing: Would like to see comparisons of pre-KanCare and KanCare. How have patient outcomes improved? Would like to see reports that show this information. 2) Trending analysis and projection: Would like to see a report card of progress. 3) Data in a form that can be manipulated or a way for interested providers to download data: Strongly prefer the download option. Providers had previously submitted a template at the POI group, wondering if MCOs would be able to give this information back to the providers as an electronic data format for each claim if the download method is not workable. 4) Strategic decisions: Providers have fiscal decisions that stretch out at least a decade. What process will be used to evaluate where we go in the next 1 ½ years? Need visibility into the thought process of future planning. 5) KDADS portal: Described the portal and the purpose of the portal. Other issues addressed are advocacy needs, small business, uniform policies and procedures and recoup or refund. Feedback received to restart the meetings KDADS used to have where the entire community was invited and the MCOs would attend and make presentations.

Questions and Answers:

Allen Schmidt – Where do you meet?

Shirley Norris – Meet at the old state hospital grounds in Topeka or individuals can call in.

Allen Schmidt – Tour in April?

Shirley Norris – Health Home provide tours starting in April. If interested in receiving the Health Homes newsletter please leave a business card and we can e-mail it.

Russell Nittler – There is a tickler on the web page so this information can be assessed.

Lora Key – I know we are early in the process, but can you give a number of providers applying for health homes?

Kara Bruffett – We do have a self-assessment form on the KanCare website. This is one of the ways we are assessing the total number of providers.

Update from KanCare Ombudsman – Kerrie Bacon

Kerrie Bacon provided an overview of the KanCare Ombudsman Annual Report 2013. The first page of the report is a review of the activities of the Ombudsman for the first year. The second page consists of the data drawing attention to billing, change of MCO, eligibility and pharmacy which were the top four issues throughout the year. The topic for this quarter is updating the website to make it more resource driven and hope to complete within the next few weeks. In addition, we are updating a tracker to pull more data for internal use and currently advertising for a volunteer coordinator.

Review of KanCare Executive Summary – Director Kari Bruffett, Division of Health Care Finance, Kansas Department of Health and Environment

Kari Bruffett reviewed the KanCare Executive Summary dated 3.24.14. Changes to the report are as follows: The eligibility and expenditure composition, capitation payments by cohort and members by cohort include January and February 2014 data as this point. The claims paid by service category per MCO and denied claims-percentage by month and total per MCO by service category YTD (March 2013-February 2014) will be provided in a rolling calendar year. Value added services and in lieu of services (January – December 2013) included the full calendar year. The grievances and appeals turnaround time (January – March 2014) are for the first calendar year. Plan of care reductions submitted has been added to the report and will provide IDD once continuity of care period is over in 180 days. The pay for performance measures-Year One does not include the December numbers due to a lag time in reporting information.

Questions and Answers:

Michael Kennedy – On the pharmacy expense there is a big discrepancy, do you have an explanation for this?

Kari Bruffett – If you look back to membership I believe the difference in the membership mix would be part of the discrepancy.

Michael Kennedy – What is NEMT?

Kari Bruffett – Non emergency medical transportation. Each of the managed care organizations provide this as a service (Ex. transportation to appointments).

Chairman Larry Martin – Propose we do an annual assessment of where KanCare is by MCO in terms of initial goals and where we are currently. Bottom line, are we providing more effective cost care or at a minimum are we on task.

Kari Bruffett – Weekly calls have resumed with CMS. The annual report will include an update and summary of these outcomes. These reports are posted on website as submitted to CMS.

Chairman Larry Martin thanked everyone for attending the meeting and adjourned.

Next Meeting of KanCare Advisory Council – June 11, 2014, 2:00-3:30 p.m., Curtis State Office Building, Room 530